

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

618

CERTIFICATE OF DEATH

00588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 6 lyr. 20das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 703 High Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Annie	Middle -	Last Akers	4. DATE OF DEATH January 21	Month January	Day 21	Year 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 95 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. X-X-X-0000-Yes		17. INFORMANT RECORDS * Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia						24 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 422.1		DUE TO (b) Cirrhosis of Liver						Over 4 yrs.	
		DUE TO (c) Chronic Myocarditis						" "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 470.0 Generalized Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 25, 1957 , to Jan. 21, 1958 , that I last saw the deceased alive on Jan. 21, 1958 , and that death occurred at 7:30a.m. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Chesapeake, Md.		DATE SIGNED 1-21-58	
ACTUAL SIGNATURE Harry J. Crawford		M.D. E.S.S. Hospital, Cambridge, Md.							
PHYSICIAN'S NAME (Type) Dr. Harry J. Crawford									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE G. Wells Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE Al. Seauich			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial; cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF HESSEN - SUBDIVISION 1
CERTIFICATE OF DEATH

BUREAU Y. 8

JAN. 23 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb -life-50 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 West End Ave.		d. STREET ADDRESS 306 West End Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle H.	Last Applegarth	4. DATE OF DEATH Jan. 14, 1958	Month Jan.	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/1877	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Applegarth		14. MOTHER'S MAIDEN NAME Laura E. Hubbard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. William Applegarth		Address 306 West End Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Central Nervous System		Central Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust		20f. (City or town) (County) (State) Cambridge	
21. I certify that I attended the deceased from 1/16 , 19 58 , to 1/14 , 19 58 , that I last saw the deceased alive on 1/14 , 19 58 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust Cambridge							
ACTUAL SIGNATURE 		DATE SIGNED 1/15/58					
PHYSICIAN'S NAME (Type) W.H. Hanks							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR John J. LeCompte		24b. REGISTRAR'S SIGNATURE John J. LeCompte	

DEPARTMENT OF JUSTICE - WASHINGTON, D.C.

CERTIFICATE OF DECAY

BUREAU V. S

JAN 20 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

593

Item 9 Film G225 2-10-58 et

Reg. Dist. No.

00590

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 Pine Street		d. STREET ADDRESS 101 Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida		First Ida	Middle Jane	Last Bazzle	4. DATE OF DEATH Jan. 27, 1958	Month Jan.	Day 27	Year 1958	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH May 14, 1879	9. AGE (In years less birthday) 78 1/2 yrs.	IF UNDER 1 YEAR Months 78 1/2	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Waters		14. MOTHER'S MAIDEN NAME Martha Adams		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or Unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Bazzle, Baltimore, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Instant					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Maryland	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/28/58			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/1958		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Stiles Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR Alfred J. Deuch		24b. REGISTRAR'S SIGNATURE			
VS. ATTSME SM 2/57		DATE FEB 7 '58							

BUREAU V. S.

FEB 7 1958

RECEIVED

SEARCHED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00591

619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1		b. COUNTY Dorchester		
c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Albert	Middle Houston	Last Bell	
4. DATE OF DEATH	Month Jan.	Day 7, 1958	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1897	
9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 60	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
13. FATHER'S NAME Daniel Bell	14. MOTHER'S MAIDEN NAME Maggie Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs. Myrtle Bell, Cambridge, Md. R.D. 1	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chr. Diodeal ulcer.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) 104 Locust St. (County) CAMBRIDGE (State) Md.
21. I certify that I attended the deceased from 1/7 , 1958, to 1/7 , 1958, that I last saw the deceased alive on 1/7 , 1958, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Kenneth R. Shoumard ADDRESS (Street, city or town, State) 104 Locust St. CAMBRIDGE Md. DATE SIGNED 1/7/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Md. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shoumard		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR JAN 9 '58	24b. REGISTRAR'S SIGNATURE Albert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HAWAII - GOVERNOR'S

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

594

CERTIFICATE OF DEATH

Reg. Dist. No.

00592

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Betty		First Anne	Middle Brohawn
4. DATE OF DEATH Jan. 22, 1958		Last Month	Month Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 22, 1958		9. AGE (In years last birthday) yrs. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles E. Brohawn, Jr.		14. MOTHER'S MAIDEN NAME Elizabeth Callahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles E. Brohawn, Jr. Oakley St., Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Congenital Anomalies - Cretin 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-22 , 19 58 , to 1-22 , 19 58 , that I last saw the deceased alive on 1-22 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cambridge	
ACTUAL SIGNATURE Sgt. Baumann		DATE SIGNED Jan. 23, 1958	
PHYSICIAN'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 23, 1958	22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JAN 27 '58
			24b. REGISTRAR'S SIGNATURE Asst. Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HIGHER EDUCATION
CERTIFICATE OF DEATH

BUREAU V.

JAN 27 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

620

CERTIFICATE OF DEATH

00593

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3		d. STREET ADDRESS RFD #3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Matilda	Middle Cornish	Last Jan 20, 1958	4. DATE OF DEATH Month Jan	Day 20	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1887	9. AGE (in years lost birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Dots Hours Min.		
10a. JESTAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Columbus Wheatley		14. MOTHER'S MAIDEN NAME Adeline Morris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Ernest Cornish, RFD #3 Cambridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Liesosarcoma uterus						INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1846 Locust St.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/20 , 19 58 , to 1/27 , 19 58 , that I last saw the deceased alive on 1/27 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE W.H. Hancks				ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED 1/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1958		22c. NAME OF CEMETERY OR CREMATORIUM Beckwith Cemetery		22d. LOCATION (City, town, or county) RFD #3 Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert McCloud		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 7 1958		24b. REGISTRAR'S SIGNATURE Alt. couch	

BURAU A. S.

FEB 7

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

595

CERTIFICATE OF DEATH

00594

Reg. Dist. No.

After death: Page 4
 by the funeral director.
 If this certificate has been signed by the attending physician and completed
 by the hospital or attending physician, it should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 40 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Cambridge Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Nellie	Middle M.	Last Creighton	4. DATE OF DEATH Jan. 14, 1958	Month Jan.	Day 14	Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1873	9. AGE (in years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Elizabeth Hughes		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Amos Creighton		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 200X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH 3 months		
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----						
20c. TIME OF INJURY Hour a. m. p. m.	Month --	Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from October 14 1957 to January 14 1958 , that I last saw the deceased alive on January 14 1958 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Eldridge H. Wolff ADDRESS (Street, city or town, state) M.D. 15 Locust Street Cambridge, Maryland DATE SIGNED 1-19-58								
PHYSICIAN'S NAME (Type) Eldridge H. Wolff								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 1/17/58		24b. REGISTRAR'S SIGNATURE LeCompte		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

621

CERTIFICATE OF DEATH

00595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Byr. 6mo. 9das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS R.F.D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lizzie	Middle -	Last Davenport	4. DATE OF DEATH	Month January	Day 28	Year 19 58
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869 ?	9. AGE (In years lost birthday) 89 ? yrs.	IF UNDER 1 YEAR Months 89	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown (Coby)		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH Sev. Yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stoling the under- lying cause lost. (b) General Arteriosclerosis						" "	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Assoc. With Senile Brain Disease, With Psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic Brain Syndrome Assoc. With Senile Brain Disease, With Psychosis					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1954 , to January 28 1958 , that I last saw the deceased alive on January 28, 1958 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 1-29-58	
ACTUAL SIGNATURE <i>Dr. Simon Virkutis</i>							
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 31-1958		22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery, Hedgesboro		22d. LOCATION (City, town, or county) Hedgesboro (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. McAllister, Easton, Md.</i>		ADDRESS <i>John W. McAllister, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 31 '58		24b. REGISTRAR'S SIGNATURE <i>C. Lee</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00596

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be given for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u>		596		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
				d. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN lb <u>10 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lee Drive Lodgecliffe</u>				d. STREET ADDRESS <u>Lee Drive Cambridge Md.</u>	
3. NAME OF DECEASED (Type or print) <u>S. Owen</u>		First	Middle	Last	4. DATE OF DEATH <u>Jan. 12, 1958</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>8/25/1917</u>	9. AGE (in years from birthday) <u>40 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship building</u>		11. BIRTHPLACE (State or foreign country) <u>Marblehead, Mass.</u>	
13. FATHER'S NAME <u>Capt. Henry F. D. Davis USN Ret.</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Grant</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>World War II 579-12-0089</u>		17. INFORMANT <u>Mrs. Owen Davis</u> Address <u>Lee Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Jr. John Ace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/15/58
EXAMINER'S NAME (Type) Jr. John Ace Jr.	22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 1/15/57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Cemetery	22d. LOCATION (City, town, or county) Arlington	(State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.	24a. REC'D BY REGISTRAR DATE 1/15/58				24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00597

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 207 Academy St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Preston		First E.	Middle Dean	Last Jan.	DATE OF DEATH 1, 1958	Month Jan.	Day 1	Year 58	
5. SEX Male		6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/17/1893	9 AGE (In years last birthday) 61 65 yr.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 65	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Wingate Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William C. Dean				14. MOTHER'S MAIDEN NAME Laura Robinson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-1805		17. INFORMANT Mrs. Fred Robinson		Address Toddville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		PERFORATION OF SIGMOID				INTERVAL BETWEEN ONSET AND DEATH 3 Days			
Carcinoma of sigmoid						Under			
Miliary tuberculosis of lungs						UNDET			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CCSA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____ 7/8, 1958, to _____ 7/11, 1958, that I last saw the deceased alive on _____ 7/11, 1958, and that death occurred at 2:30 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D.				ADDRESS (Street, city or town, state) 136 RACE ST CAMBRIDGE, MD.		DATE SIGNED 7/15/58			
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/57		22c. NAME OF CEMETERY OR CREMATORIUM Crapo Church Cemetery		22d. LOCATION (City, town, or county) Crapo		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D. BY REGISTRAR JAN 20 1958 DATE		24b. REGISTRAR'S SIGNATURE LeCompte			

BERNARD V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8. See Birth Cert. # 23992 et.
598 CERTIFICATE OF DEATH(HHS)
00598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		b. COUNTY Dorchester Co.	
c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 319 Choptank Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jerry	Middle 	Last Elliott
4. DATE OF DEATH	Month Jan.	Day 13,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/15/54
9. AGE (In years (last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cambridge Md.
13. FATHER'S NAME Ernest Elliott		14. MOTHER'S MAIDEN NAME Pauline Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Pauline Thomas	Address 319 Choptank Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X DUE TO CEREBRAL OEDEMA INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) cause undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 46-58 , 19, to 1-13-58 , 19, that I last saw the deceased alive on 1-12-58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Albert E. Bunker, M.D. 200 Maryland Avenue, Cambridge, Maryland 1-15-58			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/57	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE JAN 2 1958		24b. REGISTRAR'S SIGNATURE LeCompte	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 2

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FOR STATE
HEALTH DEPT.

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1. PLACE OF DEATH ■ COUNTY		Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RED DENIM ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cambridge Md.		20 Yrs.		Cambridge Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sunburst Hwy.							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day
Octavia		G.	Elliott		Jan.	27,	19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8/31/1873	84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None							
10b. KIND OF BUSINESS OR INDUSTRY None							
11. BIRTHPLACE (State or foreign country) Drawbridge Md.							
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William O. Elliott							
14. MOTHER'S MAIDEN NAME Amanda Horseman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No							
16. SOCIAL SECURITY NO. None							
17. INFORMANT Mrs. John Rose Cambridge Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 9040 DUE TO Terminal Pneumonia Conditions, if any, which gave rise to immediate cause (b) DUE TO Fracture neck Left femur (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Slipped and fell in home							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge	(County) Dor	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/20/58			
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Vienna Cemetery		22d. LOCATION (City, town, or county) Vienna	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.							
24a. REC'D. BY REGISTRAR FEB 6 1958				24b. REGISTRAR'S SIGNATURE <i>P. L. - educh</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

690

CERTIFICATE OF DEATH

00600

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please mail carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		b. COUNTY Dorchester Co.	
c. LENGTH OF STAY IN 1b 30 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 West End Ave.		d. STREET ADDRESS 123 West End Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Spencer	Middle W.	Last Forrest
4. DATE OF DEATH	Month Jan.	Day 15, 19	Year 573
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/1902
9. AGE (In years last birthday) 55	10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Hollands Island, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Forrest		14. MOTHER'S MAIDEN NAME Ella Bradshaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes		16. SOCIAL SECURITY NO. 220-16-9502	
17. INFORMANT Mrs. Spencer Forrest		Address 123 West End Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-14 , 19 58 , to 1-15 , 19 58 , that I last saw the deceased alive on 1-15 , 19 58 , and that death occurred at 2:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. J. Bannerman		ADDRESS (Street, city or town, state) Cambridge, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 1-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/57	
22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge	
(State) Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE JAN 22 '58		24b. REGISTRAR'S SIGNATURE J. J. Bannerman	

BUKHAU N. S.

659



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00601

622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Elwood		d. STREET ADDRESS Near Elwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Trenda	Middle Lee	Last Friend	4. DATE OF DEATH Month January	Day 28	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 29, 1957	9. AGE (In years lost birthday) yrs 8	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 29	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Larry Lewis Perry				14. MOTHER'S MAIDEN NAME Rosezina Friend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Rosezina Friend, Hurlock, Maryland, R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Bronch.) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH P-36			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/27 , 19 58 , to 1/28 , 19 58 , that I last saw the deceased alive on 1/27 , 19 58 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harold B. Plummer M.D. Rector Hurlock ADDRESS (Street, city or town, state) Rector Hurlock, Maryland DATE SIGNED 1/29/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery	22d. LOCATION (City, town, or county) Hurlock, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JAN 31 '58	24b. REGISTRAR'S SIGNATURE Webb		

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death; it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K.L.D.

JAN 31 1958

REGELIVE

00602

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

6-1

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ~~funeral~~ director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		d. STREET ADDRESS 111 Locust St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Isabelle Lewis Gray		First	Middle	Last	4. DATE OF DEATH Jan. 8, 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1894	9. AGE (in years at birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Summerfield Lewis		14. MOTHER'S MAIDEN NAME Ida Mills						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clyde H. Henry, Cambridge, Md. R.D. 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH 30 min.		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b)		DUE TO						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/10/58				
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shouley</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JAN 14 1958		24b. REGISTRAR'S SIGNATURE <i>John L. ... euek</i>		

BUREAU V. 2

JAN 12 1960

RECEIVED

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be forwarded to the Board of Health.
10 FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit permit. File Pages 1 and 2 with the funeral director, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00603

1 PLACE OF DEATH a. COUNTY Dorchester Co.		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Md. b. COUNTY Dorchester Co.		Reg. Dist. No.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson Md.		c. LENGTH OF STAY IN 1b 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hudson Md.		d. STREET ADDRESS Hudson Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Daisey	Middle Marshall	Last Hubbard	4 DATE OF DEATH Month Jan. Day 8, Year 1958
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1878	9. AGE (In years from birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cason's Neck Md.
13. FATHER'S NAME William Marshall		14. MOTHER'S MAIDEN NAME Anna Seward		15. IF UNDER 1 YEAR Months Days Hours Min.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John R. Hubbard
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		Coronary occlusion		Address Hudson Md.
				INTERVAL BETWEEN DEATH AND DEATH 5 Min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/9/58	
EXAMINER'S NAME (Type) John Mace Jr.	22c. NAME OF CEMETERY OR CREMATORIAL Speddens Seward		22d. LOCATION (City, town, or county) James Md.	
22b. DATE THEREOF REMOVAL (Specify) Burial 1/11/58	22e. ADDRESS LeCompte Funeral Service Cambridge Md.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
23. FUNERAL DIRECTOR'S SIGNATURE			24b. REGISTRAR'S SIGNATURE <i>W. J. Edwards</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00604

602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 Washington Street		e. STREET ADDRESS 169 Washington Street	
3. NAME OF DECEASED (Type or print) Josiah		First M.	Middle Johns
4. DATE OF DEATH Jan. 10 1958	Month Jan.	Day 10	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1896
9. AGE (In years lost birthday) 61 yrs		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah Johns, Sr.		14. MOTHER'S MAIDEN NAME Teenie Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 66666-217-10-8287	
17. INFORMANT Hattie Johns, Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH several days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischaemic Thrombosis		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO (c) Arterio-venous fistula?		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1957 to Jan 13, 1958 that I last saw the deceased alive on Aug. 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Jan 13, 1958	
ACTUAL SIGNATURE J. D. Thompson		PHYSICIAN'S NAME (Type) Bethel Cemetery	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. DeClue Jr.		24a. REC'D BY REGISTRAR DATE JAN 13 '58	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE D. DeClue	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1931
FBI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 2-24-58 et

00605

603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 9 Schoolhouse Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Schoolhouse Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Catherine		First	Middle	Last	4. DATE OF DEATH Jones	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown Approx. 80th	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Allen		14. MOTHER'S MAIDEN NAME Mary Cephas							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Neholma Brummell, Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO <i>Cardiac decompensation</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Astensis & arteriosclerosis heart disease		DUE TO c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 237 Pine Cambridge, Md.		(County)	(State)
21. I certify that I attended the deceased from July , 19 58 , to 6 Jan , 19 58 that I last saw the deceased alive on 5 Jan , 19 58 , and that death occurred at M. from the causes and on the date stated above.									
ACTUAL SIGNATURE John Allen		ADDRESS (Street, city or town, state) 11 Jones							
PHYSICIAN'S NAME (Type) John Allen		DATE SIGNED 11 Jan 58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/1958		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Clark Jr.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR HN 20 '58		24b. REGISTRAR'S SIGNATURE John Allen			

S A M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

624

CERTIFICATE OF DEATH

Reg. Dist. No.

00606

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head Md.		c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bishops Head Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head Md.			
f. STREET ADDRESS Bishops Head Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edgar	First J.	Middle J.	Last Jones		
4. DATE OF DEATH Jan. 23, 1958	Month Jan.	Day 23	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1889		
9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR Months 68	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) Bishops Head Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Fallin G. Jones	14. MOTHER'S MAIDEN NAME Angenora Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-32-0986	17. INFORMANT Mrs. Kathleen Abbott	Address Bishops Head Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Metastatic carcinoma Lung 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Largo Court	20f. (City or town) Cambridge	(County) MD	(State) MD
21. I certify that I attended the deceased from 9/10 , 19 58 , to 1/23 , 19 58 , that I last saw the deceased alive on 1/43 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CAMBRIDGE MD.					
ACTUAL SIGNATURE 	DATE SIGNED 1/24/58				
PHYSICIAN'S NAME (Type) W.H. Hanks					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/26/58	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE JAN 2, 58	24b. REGISTRAR'S SIGNATURE W.H. Hanks		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. C

JAN 27 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

625 CERTIFICATE OF DEATH

Reg. Dist. No. 00607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Post and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Rockville Maryland		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 7 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) Or INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
3. NAMES OF DECEASED (Type or print)		First	Middle			
		Lester	T. J.			
4. DATE OF DEATH		Month	Day			
		1	27			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
			b. DATE OF BIRTH 11/15/1877			
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
		73 yrs.	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			
Cobbler		Cobbler	England 1873			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME				
		Greensburg Jones				
14. MOTHER'S MAIDEN NAME		Sally Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT			
No			John Jones			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		422.1				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO				
{		(b)				
DUE TO		(c)				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Nephritis				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from		11/11/1877, 19		to	19	that I last saw the deceased
alive on		11/27/1958		and that death occurred at	3:45 P.M.	from the causes and on the date stated above.
ACTUAL SIGNATURE		Edwin J. Ward		ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)				DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) Mt. Michael		
Burial		1/29/58	Clint Cemetery	Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Hamilton Harrison, Esq. Michael		md.	Jan 31 '58	Delecia		

U.S.

JAN 31 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

626 CERTIFICATE OF DEATH

Reg. Dist. No.

00608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek		c. LENGTH OF STAY IN 1b 70 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Church Creek				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sarah		First	Middle Fitzhugh	Last Jones	4. DATE OF DEATH Jan. 22, 1958	Month Jan.	Day 22	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1862		9. AGE (In years less birthday) 95 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Woolford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Levin W. Fitzhugh		14. MOTHER'S MAIDEN NAME Sarah E. Linthicum						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Lillian J. Brummette, Church Creek, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary Heart Disease				10 yr.		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>1/21/58</u> , 19 <u>to</u> <u>1/22/58</u> , 19 <u>at</u> <u>8:00P.M.</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>1/23/58</u>		
ACTUAL SIGNATURE <u>Lawrence Maryanov</u>		PHYSICIAN'S NAME (Type) Lawrence Maryanov, M.D.		22d. LOCATION (City, town or county) Church Creek, Md.		(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Cemetery	22d. LOCATION (City, town or county) Church Creek, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Lewis</u>		ADDRESS Cambridge, Md.		24a. REC'D. BY REGISTRAR JAN 27 1958	24b. REGISTRAR'S SIGNATURE <u>John B. Lewis</u>			
				DATE				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00609

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the appropriate Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale			c. LENGTH OF STAY IN 1b Unknown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENT ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Hayward	Middle Cyrus	Last Joyce	4. DATE OF DEATH Month 1	Day 15
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH About 1873	9. AGE (in years at time of death) About 84	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Accomack Co., Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-2476		17. INFORMANT Address Warren McWilliams, Rhodesdale, Md., R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John MacC Jr.</i>		EXAMINER'S NAME (Type) John MacC Jr.		DATE SIGNED 1/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 20, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery	22d. LOCATION (City, town, or county) Rhodesdale, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JAN 22 '58	24b. REGISTRAR'S SIGNATURE <i>edwch</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

628

CERTIFICATE OF DEATH

Reg. Dist. No.

40610

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Route 1							
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First DAVID		Middle THOMAS	Last LLOYD	4. DATE OF DEATH	Month Jan.	Day 2	Year 19 58		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4/8/84	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Lloyd				14. MOTHER'S MAIDEN NAME Georganna Jackson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			17. INFORMANT			Address eastern Shore State hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) General arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19				20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 12/31, 1954, to 1/2, 1958, that I last saw the deceased alive on Jan 2nd, 1958, and that death occurred at 12:25 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 1/2/58											
ACTUAL SIGNATURE Thomas J. Lredge		PHYSICIAN'S NAME (Type) Thomas J. Lredge									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 5/1958				22b. DATE THEREOF Jan 5/1958			22c. NAME OF CEMETERY OR CEMETORY Crampton		22d. LOCATION (City, town, or county) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill, Md.				ADDRESS			24a. REC'D BY REGISTRAR DATE Jan 6, 1958		24b. REGISTRAR'S SIGNATURE W. McMurphy		

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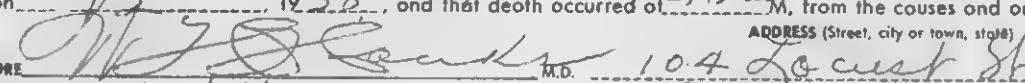
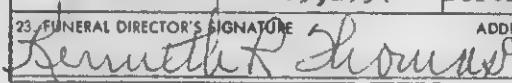
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

604

CERTIFICATE OF DEATH

00611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 212 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kenneth	Middle Paul	Last Mason	4. DATE OF DEATH Jan. 3, 1958	Month Jan.	Day 3	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1915	9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Wire Cloth Mfg. Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest S. Mason		14. MOTHER'S MAIDEN NAME Cora Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 214-10-6926		17. INFORMANT Cora Mason, 212 Race St., Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		Myocardial Failure				INTERVAL BETWEEN ONSET AND DEATH	
		Coronary Artery Thrombosis.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephroses acute						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. July 10 1957 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State) 104 Locust St. Cambridge, Maryland	
21. I certify that I attended the deceased from July 10, 1957 to 1, 1958 , that I last saw the deceased alive on 13, 1958 , and that death occurred on 1, 1958 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 104 Locust St. Cambridge, Maryland		DATE SIGNED 13/58	
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) W. H. Hanks					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '58		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00612

FOR STATE
HEALTH DEPT.

1
RECEIVED MEDICAL DIRECTOR: This certificate shall be filed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 50 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Timothy		First Timothy	Middle Mc Coy
4. SEX Male		5. COLOR OR RACE Negro	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH Aug. 23, 1957		8. AGE (In years last birthday) 5 yrs.	
9. IF UNDER 1 YEAR Months 5 Days 0		10. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philmore Mc Coy		14. MOTHER'S MAIDEN NAME Jessie Kane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Jessie McCoy		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute gastroenteritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/3/58	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2 /58	
22c. NAME OF CEMETERY OR CREMATORIUM Madison Cemetery		22d. LOCATION (City, town, or county) Madison (State)	
23. FUNERAL DIRECTOR'S SIGNATURE herbert St. Clair Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 7 '58	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Alb. edw.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00613

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 9mos. 4 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Howard	Middle -	Last McQuay
4. DATE OF DEATH	Month Jan.	Day 1	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> - DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-7-1890
9. AGE (In years lost birthday) 67 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	11. KIND OF BUSINESS OR INDUSTRY Waterman	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. FATHER'S NAME Robert McQuay		
15. MOTHER'S MAIDEN NAME Josephine James.	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Eastern Shore State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Bronchopneumonia.			
DUE TO (b) Generalized Arteriosclerosis with Heart Disease, DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 das.			
Several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X Hemoplegia right.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-28 , 19 57 , to Jan. 1 , 19 58 , that I last saw the deceased alive on Jan. 1 , 19 58 , and that death occurred at 11:00P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Simon Virkutis , M.D. Eastern Shore State Hospital, 1/1/58.			
DATE SIGNED			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Simon Virkutis			
22a. BURIAL CREMATION, REMOVAL (Specify) 1/4/58	22b. DATE THEREOF 1/4/58	22c. NAME OF CEMETERY OR CREMATORIUM Bozman	22d. LOCATION (City, town, or county) Bozman Md.
23. FUNERAL DIRECTOR'S SIGNATURE Norman L. Marshall St. Michaels	ADDRESS Bozman	24a. REC'D BY REGISTRAR DATE Jan 7 1958	24b. REGISTRAR'S SIGNATURE W. E. ...

HOSPITAL ATTENDANT PHYSICIAN: This law requires that the death certificate be submitted within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00614

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		606 Dorchester		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution, Residence before admission] a. STATE Maryland		Reg. Dist. No.			
b. CITY OR TOWN (If outside corporate limits, write RURAL) Cambridge		c. LENGTH OF STAY IN 1b 10 yrs.		d. STREET ADDRESS 410 Henry St.		b. COUNTY Dorchester					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital						e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Amos	Middle A. Meredith	Lost	4. DATE OF DEATH	Month Jan.	Month Doy 20	Year 1958			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/09		9. AGE (In years at time of death) 29 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during working life, if not retired) Mechanic, Auto		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Somerset Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Elva Meredith		14. MOTHER'S MAIDEN NAME Sadie Hurley				Address Cambridge, Md.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 212-18-6467		17. INFORMANT Amos R. Meredith		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 20 min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		<i>John Mace Jr.</i>								DATE SIGNED 1/20/58	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL/CREMATION, REMOVAL (Specify) Jan 23 1958		22b. DATE THEREOF Jan 23 1958		22c. NAME OF CEMETERY OR CREMATORIUM Sunny Ridge		22d. LOCATION (City, town, or county) Criefield, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw, Criefield, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 28 '58		24b. REGISTRAR'S SIGNATURE <i>Dee Lewis</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

630

CERTIFICATE OF DEATH

00615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 yr. 1 mo. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS 735 East Church St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Florence	Last Morris	4. DATE OF DEATH January	Month 13	Day 1958	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1893 Aug. 7, 1893	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli P. Jones				14. MOTHER'S MAIDEN NAME Clarissa Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Arthur G. Morris Husband RECORDS: Easter Shore State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422,1 DUE TO Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH —	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO Chronic Myocarditis —		(b) DUE TO Arteriosclerosis —		(c) DUE TO —		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 491X —	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27, 1956, to 1-13, 1958, that I last saw the deceased alive on 1-13, 1958, and that death occurred at 1:20 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Simon Virkutis</i>		ADDRESS (Street, city or town, state) Eastern Shore State Hospital, Cambridge, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St Johns Cemetery		22d. LOCATION (City, town, or county) Powellville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1-15-58		24b. REGISTRAR'S SIGNATURE <i>Q. J. L. 1/15/58</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1983

REGISTRY

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00616

FOR STATE
HEALTH DEPT.

NOTICE TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		607 Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cambridge		Life		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		d. DATE OF DEATH		f. IS UNDER 1 YEAR? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
419 High St		419 High St.		Jan. 31 1952		MONTH DAYS HOURS MIN	
3. NAME OF DECEASED (Type or print)		First	Middle	Month	Day	Year	
Gladys		Smith	Murray				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)		10. IF UNDER 24 HRS
Female		Legro	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	April 1, 1915	42 yrs.		Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Dry Cleaning		Maryland		USA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Vernon Hamilton Sr.		Eva Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No		Unknown		Mrs Eva Smith		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first		(b)				DUE TO	
		(c)				DUE TO	
420						INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Dr. John Luce Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/3/52	
22a. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/52		22c. NAME OF CEMETERY OR CREMATORIUM Beckwith Cemetery		22d. LOCATION (City, town, or county) Beckwith Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. StClair		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 7 '58		24b. REGISTRAR'S SIGNATURE Albert Leach	
VS. A15ME SM 2/37							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00617

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission a. STATE	
<i>Dorchester</i> MARYLAND		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glencairn Convalescent Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East New Market</i>	
3. NAME OF DECEASED (Type or print)		First <i>Amelia</i>	Middle <i>Steinman</i>
		Last <i>Patten</i>	4. DATE OF DEATH Month <i>1</i> Day <i>29</i> Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		8. b. DATE OF BIRTH <i>4/3/1877</i>	8. c. AGE (In years from birthday) <i>80 yrs.</i>
10a. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Andrew Steinman</i>		14. MOTHER'S MAIDEN NAME <i>Anna (don't know)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>J. E. Patten Cambridge Md.</i>		Address <i>123-45-6789</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Jan 22 1958</i> 19 p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) <i>None</i> (State) <i>None</i>	
21. I certify that I attended the deceased from <i>Jan 22 1958</i> to <i>Jan 28 1958</i> , that I last saw the deceased alive on <i>Jan 27 1958</i> , and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, City or town, state) <i>123-45-6789</i> DATE SIGNED <i>1-30-58</i>			
ACTUAL SIGNATURE <i>Gilbert E. Meekins</i>			
PHYSICIAN'S NAME (Type) <i>GILBERT E. MEEKINS</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>3/1/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Northwood</i>	
22d. LOCATION (City, town or County) <i>Philadelphia Pa</i>		22e. STATE <i>Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Willoughby, East New Market Md.</i>		24a. REC'D BY REGISTRAR DATE <i>1-30-58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Willoughby</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO THE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tranish permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

631

CERTIFICATE OF DEATH

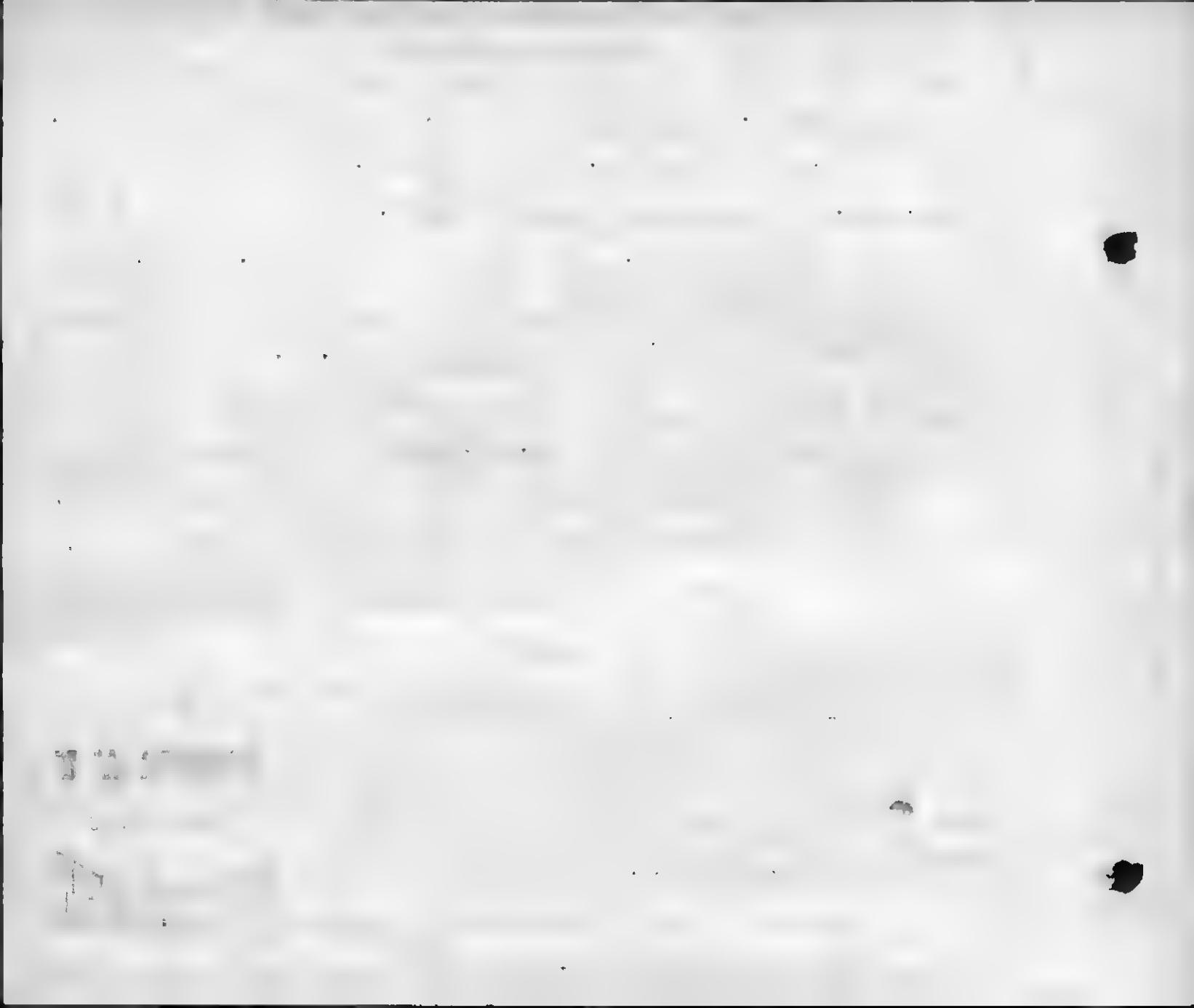
Reg. Dist. No.

00618

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 35 Yrs.		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Race St. Extd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge Md.							
3. NAME OF DECEASED (Type or print) Charles		First E.	Middle Paul	Last 	4. DATE OF DEATH Jan. 1, 1957	Month Jan.	Day 1	Year 1957	d. STREET ADDRESS Race St.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1871		9. AGE (In years last birthday) 86 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Matthew Paul		14. MOTHER'S MAIDEN NAME Jane Mc Collister		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. William Paul	Address Cambridge RFD # 1
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44dx		DUE TO Cerebral accident		INTERVAL BETWEEN ONSET AND DEATH 5 mins.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)		DUE TO Arterio sclerotic hypertensive cardio vascular		2 yrs. +							
(c) Arterio sclerosis and arteriolar sclerosis				2 yrs. +							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) -- --	(County) -- --	(State) -- --	
21. I certify that I attended the deceased from 9-2- , 19 57 , to 1-1- , 19 58 that I last saw the deceased alive on 12-31 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edridge H. Wolff PHYSICIAN'S NAME (Type) Edridge H. Wolff, M.D.		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.		DATE SIGNED 1-2-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/57	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery	22d. LOCATION (City, town, or county) Cambridge	22e. (State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE JAN 7 '58	24b. REGISTRAR'S SIGNATURE W. E. LeCompte								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00619

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		609 Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		d. STREET ADDRESS 110. #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cambridge Cambridge Maryland Hospital							
3. NAME OF DECEASED (Type or print)		First Viola	Middle Pinkett	4. DATE OF DEATH Lost	Month January	Day 31	Year 1958
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1900		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME Josiah Collins		14. MOTHER'S MAIDEN NAME Henrietta Baltimore				12. CITIZEN OF WHAT COUNTRY? USA.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Thomas R. Pinkett, Vienna, Md. 110. #1		Address	
						INTERVAL BETWEEN ONSET AND DEATH 5 min.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion							
480.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John lace</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/3/58			
EXAMINER'S NAME (Type) Jr. John lace Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/58		22c. NAME OF CEMETERY OR CREMATORIUM Thompsonstown Cemetery		22d. LOCATION (City, town, or county) Near East New Market, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son, Federalsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 6 '58		24b. REGISTRAR'S SIGNATURE <i>Bill Deere</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

632

CERTIFICATE OF DEATH

00620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Secretary Md.	c. LENGTH OF STAY IN lb 3 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Secretary Md.			b. COUNTY Dorchester Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Merrick's Convalescent Home			d. STREET ADDRESS Secretary Md.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Joseph		First H.	Middle Rathel	Last Lost	4. DATE OF DEATH Jan. 12, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1883	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. Year 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Talbot Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Rathel			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Otis Collison		Address Cambridge Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic CVD</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arterio - sclerotic generalized</i> ? (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)		
21. I certify that I attended the deceased from 1950 , to Jan 12, 1958 , that I last saw the deceased alive on July 10, 1957 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Jan 16, 1958								
ACTUAL SIGNATURE <i>J. O. Thompson</i>		PHYSICIAN'S NAME (Type) M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58		22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE John LeCompte	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with

W. A. GUNZER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00621

633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Mattie	Middle Hatten	Last Reynolds	4. DATE OF DEATH	Month January	Day 7	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-15-83	9. AGE (in years less birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Muterspaw				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT R CORDS: Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) General Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH -								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) -	(County)	(State)
21. I certify that I attended the deceased from July 8, 1957 , to January 7, 1958 , that I last saw the deceased alive on January 7, 1958 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Ettore DeFilippis</i>	M.D.							
PHYSICIAN'S NAME (Type) Ettore DeFilippis	Eastern Shore State Hospital, Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/58	22c. NAME OF CEMETERY OR CREMATORIUM Chestertown Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Willis Wells</i>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE Jan 9 '58		24b. REGISTRAR'S SIGNATURE <i>(Signature)</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

610

CERTIFICATE OF DEATH

00622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Patricia	Middle Ann	Last Rivers	4. DATE OF DEATH January	Month 31	Day 19	Year 58
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 21, 1957	8. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR 1	IF UNDER 24 HRS 10	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jimmy Lee Glover		14. MOTHER'S MAIDEN NAME Daisy Mae Rivers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Records, Cambridge Maryland Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease						INTERVAL BETWEEN ONSET AND DEATH 2	
7725 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity - 34 weeks						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 21 , 1957, to Jan. 31 , 1958, that I last saw the deceased alive on Jan. 31 , 1958, and that death occurred at 8:40 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
MEDICAL CERTIFICATION SIGNATURE Eldridge H. Wolff							
PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff		15 Locust St., Cambridge, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery		22d. LOCATION (City, town, or county) Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR EB 9 1958		24b. REGISTRAR'S SIGNATURE C. J. ... edrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

January 20, 1968

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12

00623

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be given to your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		611 Dorchester Co., Maryland		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.		Reg. Dist. No.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 16 Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 302 Academy St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 302 Academy St.								
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First F.	Middle Harvey	Last Rumbley	4. DATE OF DEATH Jan. 26, 1958	Month Jan.	Day 26	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1900	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Ship Repair		11. BIRTHPLACE (State or foreign country) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Rumbley		14. MOTHER'S MAIDEN NAME Lillie Slacum						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Howard Gray Seaford Del.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 10 min.		
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
19								
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/27/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		
						(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				24a. REC'D BY REGISTRAR DATE JAN 29 '58		24b. REGISTRAR'S SIGNATURE Allied		

BUREAU V. 5

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00624

**FOR STATE
HEALTH DEPT.**

1
 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page
 5 may be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with
 the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b All life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First Blades	Middle Smith
4. DATE OF DEATH January 4 1958	Month January	Day 4	Year 1958
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/99
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Can plant		10b. KIND OF BUSINESS OR INDUSTRY Can mfg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Smith		14. MOTHER'S MAIDEN NAME Vinnie Blades	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harry Smith		Address Hurlock, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 1/5/59	
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION Atmospheric Burial		22b. DATE THEREOF 1/5/58	
22c. NAME OF CEMETERY OR CREAMERY Passenger		22d. LOCATION (City, town, or county) Hurlock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Reed S. Ellington E. J. Miller		24a. REC'D BY REGISTRAR DATE JAN 14 '58	
		24b. REGISTRAR'S SIGNATURE Al. L. Lewis	

BUREAU V.

241 1 1533

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

612

CERTIFICATE OF DEATH

Reg. Dist. No.

00625

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Two Yrs.		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Cedar Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		f. STREET ADDRESS 218 Cedar Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Olive		First	Middle	Last	4. DATE OF DEATH Stanley	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 4, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Odessa Delaware		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Emory Webb		14. MOTHER'S MAIDEN NAME Mary Parker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT George Stanley, Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary		INTERVAL BETWEEN ONSET AND DEATH 3 days							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemiplegia, right		4 months							
DUE TO (c) arteriosclerotic hypertensive cardiac vascular renal disease		6 months+							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----							
20c. TIME OF INJURY Month Day Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) -----			
21. I certify that I attended the deceased from 3-10-57 , 19, to 1-22-58 , 19, that I last saw the deceased alive on 1-20-58 , 19, and that death occurred at M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eldridge H. Howell</i> NAME (Type) Eldridge H. Howell		ADDRESS (Street, city or town, state) M.D. 15 Locust Street, Cambridge, Md. 1-24-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/1953		22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery		22d. LOCATION (City, town, or county) (State) Salem, Dor. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert McNamee</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 7 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. - euc</i>			

HOSPITAL OR ATTENDIN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURIAU V. S.

FEB 7 1970

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14, Film 12, 2-24-58 et

635

CERTIFICATE OF DEATH

00627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	c. LENGTH OF STAY IN lb 24 days	b. COUNTY CECIL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.	d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JAMES	Middle ALONZO	Last THOMASON	
4. DATE OF DEATH	Month JANUARY	Day 31	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-78	
9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Henry Co., Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Shumase	14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 401 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. GENERAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 4 days		
b) DUE TO c) GENERAL ARTERIOSCLEROSIS		SEVERAL YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 1	Day 31	Year 1958	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Saint Marys	(County) Cambridge	(State) Md.
21. I certify that I attended the deceased from 1-7-1958 to 1-31-1958 , that I last saw the deceased alive on 1-31-1958 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) George E. Currier M.D. Saint Marys Hospital Cambridge, Md.				
ACTUAL SIGNATURE	DATE SIGNED			
PHYSICIAN'S NAME (Type) GEORGE E. CURRIER				
22a. BURIAL, CREMATION, MASSACRE (Specify) Burial	22b. DATE THEREOF Feb 4-58	22c. NAME OF CEMETERY OR CREMATORIUM Warren Cemetery	22d. LOCATION (City, town, or county) Roanoke, Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Ralph Reid	ADDRESS Rising Sun Md.	24a. REC'D BY REGISTRAR DATE FEB 3 1958	24b. REGISTRAR'S SIGNATURE John ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and is valid within 72 hours after death.

U.S. MAIL

1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00628

613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Luther	Middle Henry	Last Thompson	4. DATE OF DEATH	Month January	Day 10	Year 1958
S SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 13, 1882	9. AGE (In years lost birthday) 75 yrs	11. IF UNDER 1 YEAR Months 0	12. IF UNDER 24 HRS Days 0	13. Hours 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10. KIND OF BUSINESS OR INDUSTRY American Cannery		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Thompson				14. MOTHER'S MAIDEN NAME Margaret A. Teakle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 218-10-1589		17. INFORMANT Daniel A. Thompson, East New Market, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1							
DUE TO Arteriosclerotic Hypertension							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic Hypertension							
DUE TO Coronary Heart Disease							
INTERVAL BETWEEN ONSET AND DEATH 1 week							
DUE TO Coronary Heart Disease							
INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/28 , 19 57 to 1/10 , 19 58 that I last saw the deceased alive on 1/10/58 , 19 58 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 136 Race St.							
DATE SIGNED							
ACTUAL SIGNATURE Lawrence Maryanov							
PHYSICIAN'S NAME (Type) Lawrence Maryanov							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1958		22c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery		22d. LOCATION (City, town, or county) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JAN 15 '58	
24b. REGISTRAR'S SIGNATURE John L. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

614

CERTIFICATE OF DEATH

00626

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 28 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Lena		First Lena	Middle Augusta
3. NAME OF DECEASED (Type or print) Lena		Last Todd	4. DATE OF DEATH Jan. 30, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1887
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF ON A FARM Hours 0
13. FATHER'S NAME James Williams	14. MOTHER'S MAIDEN NAME Sarah Ryall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Louise Winters, Church Creek, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia (b) DUE TO arteriosclerosis (c)			
INTERVAL BETWEEN ONSET AND DEATH 2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis			
4.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 200 Maryland Ave.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-11- , 19 54 to 1-30- , 19 58 , that I last saw the deceased alive on 1-30- , 19 58 , and that death occurred at 10:00 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Albert E. Bunker M.D.			ADDRESS (Street, city or town, state) 200 Maryland Ave.
DATE SIGNED 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park
22d. LOCATION (City, town, or county) Cambridge, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard R. Slover		24a. ADDRESS Cambridge, Md.	24b. REC'D BY REGISTRAR FEB 3 '58
		24c. REGISTRAR'S SIGNATURE G. J. Smith	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

615

CERTIFICATE OF DEATH

00629

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 702 Maryland Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida V. Eichelberger Waddey		First	Middle	Last	4. DATE OF DEATH Jan. 15, 1958	Month	Day	Year 19	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1876	9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles E. Eichelberger		14. MOTHER'S MAIDEN NAME Louise Horpel							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James C. Garing, Sr., 702 Maryland Ave., Camb., Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiac infarction</i>		DUE TO <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH 6 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>Arteriosclerotic cardio vascular renal disease</i>		10 yrs. +					
		(c) <i>arteriosclerosis, generalized</i>		10 yrs. +					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —
21. I certify that I attended the deceased from 9-4-57 , 19, to 1-15-58 , 19, that I last saw the deceased alive on 1-15-58 , 19, and that death occurred at 7:45 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Eldridge H. Wolff, M.D., 15 August, 1958, Elbridge, Md.</i>		DATE SIGNED 1-19-58	
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>									
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Meadow Ridge Cemetery		22d. LOCATION (City, town, or county) Elkridge, Baltimore, Md.		(State) —	
23. KENNETH R. THOMAS, Kennele R. Thomas, ADDRESS Wm. J. Tickner & Sons, Baltimore,				24a. REC'D BY REGISTRAR DATE JAN 20 '58		24b. REGISTRAR'S SIGNATURE <i>Alvin Smith</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

616

CERTIFICATE OF DEATH

Reg. Dist. No.

00630

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 532 Leonards Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle W.	Last Willey Sr.	4. DATE OF DEATH	Month Jan.	Day 20,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Food Processing		11. BIRTHPLACE (State or foreign country) Seward Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Willey		14. MOTHER'S MAIDEN NAME Elnora Insley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Nellie Bramble Willey 532 Leonards La.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 8/25/1958 , to 1/19/1958 , that I last saw the deceased alive on 1/19/1958 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D. ADDRESS (Street, city or town, state) 136 RACE ST CAMBRIDGE, MD. DATE SIGNED 1/21/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/22/58	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE JAN 27 '58	24b. REGISTRAR'S SIGNATURE Alfred R. Maryanov				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HERZLICH-GELDWEHR TO

CERTIFICATE OF DEATH

BUREAU X E

JAN 27 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

617 CERTIFICATE OF DEATH

Reg. Dist. No.

00631

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS 205 Byron St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Melvin		First	Middle	Last	4. DATE OF DEATH Willey	Month Jan.	Day 20,	Year 19 58	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Macintire Willey				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry Mowbray		Address 205 Byron St. Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 381X		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerosis		(b)							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1-20-1958		(County) 1-20-1958	(State) 1-20-1958
21. I certify that I attended the deceased from 1-3- 19 45 , to 1-20- 19 58 , that I last saw the deceased alive on 1-30-1958 , and that death occurred at 12-8 M, from the causes and on the date stated above. ACTUAL SIGNATURE Albert E. Bunker						ADDRESS (Street, city or town, state) 200 Maryland Avenue		DATE SIGNED	
PHYSICIAN'S NAME (Type) Albert E. Bunker									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE JAN 29 '58		24b. REGISTRAR'S SIGNATURE Albert LeCompte			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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WISCONSIN STATE DEVELOPMENT DEPARTMENT

CERTIFICATE OF DEATH

NAME

DEATH DATE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

ADDRESS

PHONE

MARITAL STATUS

DEATH DATE

DEATH PLACE

CAUSE OF DEATH

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

BUREAU Y. S.

JAN 39 1958

RECEIVED